| | OF CORRECTION | | | ONSTRUCTION 01 | (X3) DATE SURVEY COMPLETED | | |
|---------------|--|--|---------|-------------------|--|-----------------|--------------------|
| 1111212111 | or condition. | 155224 | A. BUII | | - | 12/04/2012 | |
| | | | B. WIN | | ADDRESS CITY STATE ZIR CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE COLUMBIA ST | | |
| COLUME | BIA HEALTHCARE (| CENTER | | | SVILLE, IN 47710 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| | REGULATORY OR | LSC IDENTIF FING INFORMATION) | | TAG | Birtellivery | | DATE |
| K0000 | and State Licenconducted by the Department of accordance with Survey Date: In Facility Number Provider Number AIM Number: In Surveyor: Lexistance Safety Code Sport At this Life Safety Co | th 42 CFR 483.70(a). 2/04/12 r: 000129 er: 155224 100266780 Brashear, Life ecialist ety Code survey, thcare Center was ompliance with for Participation in caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing cupancies and 410 | K00 | 000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after December 13, 2012 | ot s n of | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

2X6G21

Facility ID:

000129

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 01 | (X3) DATE S COMPL 12/04/ | ETED |
|--------------------------|--|--|-------------------------------|---------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | | 621 W C | DDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | a fire alarm syswired smoke decorridors, space corridors, and rooms in the 1 1406, and 140 (2403 to 2410) operated smoke other resident. The facility has and had a censtime of this surface of this surface of the surf | etectors in the es open to the resident sleeping 400 hall (1403 to 8), and 2400 hall with battery e detectors in all sleeping rooms. a capacity of 186 us of 153 at the rvey. e the residents have ess were ll areas providing s were sprinklered, ached wood shed y storage. Robert Booher, Life Safety dical Surveyor on 12/07/12. | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet

Page 2 of 11

| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---------------|--|--|----------------------------|---------|---|-----------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 01 | COMPLI | ETED |
| | | 155224 | B. WING | | - <u>-</u> - | 12/04/2012 | |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | 621 W (| COLUMBIA ST | | |
| COLUME | BIA HEALTHCARE (| CENTER | | | VILLE, IN 47710 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0017 SS=E | NFPA 101 LIFE SAFETY CO Corridors are sep walls constructed resistance rating. partitions are only passage of smok buildings, walls po ceiling. (Corridor underside of ceilin permitted by Cod stations, waiting a activity spaces m under certain con Code. Gift shops corridors by non- shop is fully sprin 19.3.6.2.1, 19.3.6 Based on obser interview, the f ensure 1 of 2 k separated from partition capab passage of smo sprinklered buil Exception. LSC Exception # 6, patient sleepin rooms, and has be open to the unlimited in are | DDE STANDARD parated from use areas by with at least ½ hour fire In sprinklered buildings, a required to resist the e. In non-sprinklered roperly extend above the walls may terminate at the ngs where specifically e. Charting and clerical areas, dining rooms, and ay be open to the corridor ditions specified in the may be separated from fire rated walls if the gift klered.) 19.3.6.1, 6.5 revation and facility failed to citchenettes was a the corridor by a ble of resisting the oke as required in a filding, or met an C. 19–3.6.1, Spaces other than g rooms, treatment zardous areas may corridor and ea provided: (a) The | K00 | TAG | | s) se and ed | 12/13/2012 |
| | space and corr space opens or | idors which the nto in the same | | | taken? | | |
| | · · | tment are protected | | | ·All residents have the poten | tial | |
| | by an electrical | | | | to be affected by the alleged deficient practice. | | |
| | automatic smo | | | | ·Smoke detector has been | | |
| | | | | | installed in the kitchenette area | a | |
| | system, and (b) |) Each space is | | | that is hard wired and connecte | ed | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet Page 3 of 11

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|----------------------------|--|------------------------------|----------------------------|---|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 01 | | 01 | COMPLETED | |
| | | 155224 | | | | 12/04/2 | 2012 |
| | | | B. WING | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| COLLIME | | CENTER | | 621 W COLUMBIA ST EVANSVILLE, IN 47710 | | | |
| COLUMBIA HEALTHCARE CENTER | | | EVANS | VILLE, IN 477 IU | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | F | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | protected by a | n automatic | | | to building fire protection syste | em. | |
| | sprinklers, and | l (c) The space is | | | ·Maintenance supervisor, | | |
| | | o obstruct access to | | | ED/designee will ensure all construction changes include | | |
| | _ | This deficient | | | hard wired smoke detection | | |
| | practice could | | | | devices when required. What | | |
| | _ · | | | | measures will be put into pla | ce | |
| | | vell as staff and | | | or what systemic changes yo | | |
| | | 1400 hall, plus any | | | will make to ensure that the | | |
| | other residents | s using the 1400 | | | deficient practice does not | | |
| | hall dining roo | m/lounge which | | | recur? | | |
| | could seat mor | re than twenty | | | ·Smoke detector has been installed in the kitchenette are | _ | |
| | residents. | | | | that is hard wired and connect | - | |
| | | | | | to building fire protection syste | | |
| | Findings include: | | | | ·Maintenance supervisor, | | |
| | i mamga merae | | | | ED/designee will ensure all | | |
| | Dagad an an al | | | | construction changes include | | |
| | | oservation with the | | | hard wired smoke detection | | |
| | Maintenance D | | | | devices when required | | |
| | 12/04/12 at 1 | :20 p.m., the 1400 | | | How the corrective action(s) will be monitored to ensure t | ho | |
| | hall kitchenette | e wall had a three | | | deficient practice will not rec | - | |
| | foot by five foo | ot opening into | | | i.e., what quality assurance | ,ui, | |
| | dining room/lo | ounge which was | | | program will be put into place | e? | |
| | open to the co | | | | Safety meeting held monthly | | |
| | Furthermore, E | | | | include review of fire safety | | |
| | | = | | | requirements and review of ar | - | |
| | |) of the LSC Section | | | new construction or remodelin | g | |
| | | not met because the | | | planned. Compliance date: | | |
| | 1400 hall kitch | nenette was not | | | December 13, 2012 | | |
| | protected by a | n electrically | | | | | |
| | supervised aut | omatic smoke | | | | | |
| | detection syste | em. This was | | | | | |
| | acknowledged | by the Maintenance | | | | | |
| | Director at the | - | | | | | |
| | observation. | | | | | | |
| | observation. | | | | | | |
| | | | | | | | |
| | 3.1-19(b) | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet Page 4 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | (X3) DATE S COMPLI 12/04/ | ETED |
|--------------------------|----------------------------------|---|--|---|---------------------------------|----------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP COE COLUMBIA ST | DE . | |
| COLUME | BIA HEALTHCARE | CENTER | | SVILLE, IN 47710 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet

Page 5 of 11

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---------------------|---|--------------------------|--------|---|--------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING O1 COMPLETED | | | ETED | |
| | | 155224 | B. WING | | | 12/04/ | 2012 |
| | | | <u> </u> | _ | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | COLUMBIA ST | | |
| COLUMB | IA HEALTHCARE | CENTER | | EVANS' | VILLE, IN 47710 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| K0029 SS=D | | ed construction (with 3/4 | | | | | |
| | | ors) or an approved | | | | | |
| | | inguishing system in 3.4.1 and/or 19.3.5.4 | | | | | |
| | | us areas. When the | | | | | |
| | • | tic fire extinguishing | | | | | |
| | | used, the areas are | | | | | |
| | • | ther spaces by smoke | | | | | |
| | | s and doors. Doors are | | | | | |
| self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are | | | | | | | |
| | | | | | | | |
| | permitted. 19.3.2.1 | | | | | | |
| | Based on obse | vation and | K002 | 29 | K029What corrective action(s | s) | 12/13/2012 |
| | interview, the f | acility failed to | | | will be accomplished for thos | | |
| | ensure 4 of 5 s | ets of double | | | residents found to have been | 1 | |
| | doors, hazardo | ous area doors, to | | | affected by the deficient practice? | | |
| | the basement o | corridor were | | | ·No residents were affected and alleged deficiency has been | | |
| | equipped with | positive latches and | | | | | |
| | latched into the | eir door frames. | | | corrected. ·All doors required to have | | |
| | This deficient p | oractice could affect | | | positive latches and latch into | | |
| | mostly staff an | d visitors while in | | | their door frames have been | | |
| | the basement a | area which included | | | installed. How will you identify | y | |
| | the kitchen, lau | undry room, and | | | other residents having the | | |
| | maintenance ro | • | | | potential to be affected by the same deficient practice and | 9 | |
| | | | | | what corrective action will be | , | |
| | Findings includ | le· | | | taken? | | |
| | | | | | ·All residents have the poten | tial | |
| | Based on obse | rvations on | | | to be affected by the alleged | | |
| | | veen 12:15 p.m. | | | deficient practice. All doors required to have | | |
| | | . during a tour of | | | positive latches and latch into | | |
| | | - | | | their door frames have been | | |
| | - | the Maintenance | | | installed. | | |
| | | ets of double doors | | | ·Maintenance supervisor, | | |
| | trom the corrid | lor into the kitchen | | | ED/designee will ensure all | | |
| | | | | | construction changes include of | or | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet Page 6 of 11

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTII | PLE CO | NSTRUCTION | (X3) DATE S | | |
|--|----------------------|------------------------------|----------------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 01 | | 01 | COMPLETED | |
| | | 155224 | B. WING | | | 12/04/2 | 2012 |
| NAME OF P | PROVIDER OR SUPPLIER | | ST | REET A | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | COLUMBIA ST | | |
| COLUME | BIA HEALTHCARE (| CENTER | E۱ | /ANS\ | VILLE, IN 47710 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | PREI | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TA | .G | | | DATE |
| | (2 sets), Mainte | enance Room, and | | | future installation of doors hav required positive latches that a | | |
| | Boiler Room, w | ould latch into each | | | latch to their frame when | 1150 | |
| | other, however | , all four sets of | | | required. | | |
| | double doors v | vould not latch into | | | What measures will be put in | to | |
| | their respective | e door frames. This | | | place or what systemic | | |
| | was acknowled | | | | changes you will make to | | |
| | | irector at the time | | | ensure that the deficient | | |
| | of each observ | | | | practice does not recur? Aud of all double doors in facility ha | | |
| | 2. cac., 003ci V | ~ | | | been conducted by the | ~ | |
| | 3.1-19(b) | | | | maintenance director and all a | re | |
| | 3.1-19(b) | | | | equipped with positive latch do | oors | |
| | | | | | that latch to the frame as | | |
| | | | | | required. Any changes in doo will be reviewed, department | rs | |
| | | | | | heads will report any concerns | , | |
| | | | | | about properly functioning doc | | |
| | | | | | to maintenance supervisor/ | | |
| | | | | | ED/designee immediately. Hov | | |
| | | | | | the corrective action(s) will b | e | |
| | | | | | monitored to ensure the deficient practice will not rec | ur | |
| | | | | | i.e., what quality assurance | ui, | |
| | | | | | program will be put into plac | e? | |
| | | | | | Safety meeting held monthly | | |
| | | | | | include review of fire safety | | |
| | | | | | requirements and review of an | - | |
| | | | | | new construction or remodelin | g | |
| | | | | | planned.Compliance date: December 13, 2012 | | |
| | | | | | 2000111001 10, 2012 | | |
| | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet Page 7 of 11

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | | SURVEY | | | |
|--|--|---|-------------|--------|--|--------|------------|--|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | 01 | COMPL | COMPLETED | |
| | | 155224 | B. WIN | | | 12/04/ | 2012 | |
| | | | D. 1111 | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | COLUMBIA ST | | | |
| COLUMB | IA HEALTHCARE (| CENTER | | | VILLE, IN 47710 | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | ГЕ | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| K0045 | NFPA 101 | DE 07411D4DD | | | | | | |
| SS=E | LIFE SAFETY CO | · · · · · | | | | | | |
| | | eans of egress, including arranged so that failure of | | | | | | |
| | | g fixture (bulb) will not leave | | | | | | |
| | | ess. (This does not refer to | | | | | | |
| | | ig in accordance with | | | | | | |
| | section 7.8.) | | | | | | 12/12/2012 | |
| | Based on obse | | K00 |)45 | K045 What corrective action(| | 12/13/2012 | |
| | interview, the facility failed to | | | | will be accomplished for those residents found to have been | | | |
| | | ting for 1 of 6 exit | | | affected by the deficient | • | | |
| | means of egres | ss were arranged so | | | practice? | | | |
| | the failure of a | ny single lighting | | | ·No residents were affected | and | | |
| | fixture (bulb) w | ould not leave the | | | alleged deficiency has been | | | |
| | area in darknes | ss. This deficient | | | corrected. | | | |
| | practice could | affect 30 residents, | | | ·A second light has been installed at the 1100 hall exit | | | |
| | - | and visitors from | | | How will you identify other | | | |
| | | 2100 halls while | | | residents having the potentia | ıl | | |
| | using the 1100 | | | | to be affected by the same | | | |
| | evacuate the fa | | | | deficient practice and what | _ | | |
| | evacuate the la | icincy. | | | corrective action will be take 30 residents, as well as state | | | |
| | Findings includ | le: | | | and visitors using the 110 and | | | |
| | i manigs merae | ic. | | | 2100 halls have the potential t | | | |
| | December of the contract of th | | | | be affected by the alleged | | | |
| | Based on obser | | | | deficient practice | | | |
| | | 50 p.m. during a | | | ·A second light has been installed at the 1100 hall exit. | | | |
| | tour of the faci | • | | | ·Maintenance supervisor, | | | |
| | | irector, the exit | | | ED/designee will ensure all ex | its | | |
| | means of egres | ss outside the 1100 | | | are equipped with lighting as | | | |
| | hall exit was ed | quipped with one | | | required. | | | |
| | light fixture wi | th only one bulb | | | What measures will be put in | to | | |
| | under the three | e foot soffit. Once | | | place or what systemic changes you will make to | | | |
| | outside the exi | t there was a ramp | | | ensure that the deficient | | | |
| | and sidewalk o | ver 75 feet to the | | | practice does not recur? Aud | it | | |
| | public way. Th | is was | | | has been conducted and all | | | |
| | · · | by the Maintenance | | | public exits are equipped with | | | |
| | z.m.o.meagea | a, and mannedianee | | | I | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet

Page 8 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/18/2012 FORM APPROVED OMB NO. 0938-0391

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224 | (X2) MULTIPLE CO A. BUILDING B. WING | 01 | | | | |
|--------------------------|----------------------------------|---|---|--|---|----------------------------|--|--|
| NAME OF | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP C | ODE | | | |
| COLUM | BIA HEALTHCARE | CENTER | 621 W COLUMBIA ST EVANSVILLE, IN 47710 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | |
| TAG | Director at the observation, fu | time of orthermore, the orector said he did orgle light was | TAG | lighting requirements in least 2 lights per exit. In corrective action(s) we monitored to ensure the deficient practice will i.e., what quality assure program will be put in Safety meeting held monitored in modern the program will be put in Safety meeting held modern include review of fire some requirements and review on the supervisor of the program of the program of the program will be put in Safety meeting held modern in working or requirements and review on the supervisor of the program of the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the program will be put in Safety meeting held modern the | ncluding at How the iill be he not recur, rance nonthly will afety ew of any modeling e will EX per eekly months to nctioning | DATE | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet

Page 9 of 11

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI | | | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|----------------|---|---|----------------------------------|-----------------|--|-----------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUII | UILDING 01 COMP | | COMPL | ETED |
| | | 155224 | B. WIN | | | 12/04/ | 2012 |
| NAME OF D | ROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 621 W (| COLUMBIA ST | | |
| COLUME | BIA HEALTHCARE (| CENTER | | EVANS | VILLE, IN 47710 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCI) | | DATE |
| TAG K0056 SS=D | NFPA 101 LIFE SAFETY CO If there is an auto installed in accord Standard for the I Systems, to provi all portions of the properly maintain NFPA 25, Standa Testing, and Mair Fire Protection Sy supervised. Ther water supply for t sprinkler systems flow and tamper se electrically conne alarm system. Based on obser interview, the f provide an auto system that pro coverage in 2 c compartments. practice could and visitors wh which included | DDE STANDARD matic sprinkler system, it is dance with NFPA 13, nstallation of Sprinkler de complete coverage for building. The system is ed in accordance with ord for the Inspection, ntenance of Water-Based ystems. It is fully e is a reliable, adequate the system. Required are equipped with water switches, which are cted to the building fire 19.3.5 rvation and facility failed to comatic sprinkler ovided complete of 17 smoke This deficient affect mostly staff file in the basement the kitchen, and maintenance | K00 | TAG | K056 What corrective action(will be accomplished for thos residents found to have been affected by the deficient practice? No residents were affected alleged deficiency has been corrected. Sprinklers have been install in both elevator rooms in the basement How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. All residents, as well as staffered. | s) se and ed | 12/13/2012 |
| | Based on obse | vations on | | | and visitors have the potential | | |
| | | | | | be affected by the alleged | | |
| | | 1:50 a.m. and again | | | deficient practice | . d | |
| | - | during a tour of the | | | ·Sprinklers have been install in both elevator rooms in the | eu | |
| | facility with the | | | | basement. | | |
| | • | evator room near | | | What measures will be put in | to | |
| | the employee b | oreak room and the | | | place or what systemic | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2X6G21

Facility ID: 000129

If continuation sheet

Page 10 of 11

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | | (X3) DATE SURVEY | | | | |
|--|----------------------|---|---|---|--------------------|--|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 01 | COMPLETED | | | |
| | | 155224 | B. WING | | 12/04/2012 | | | |
| NAME OF P | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| COLUMB | BIA HEALTHCARE | CENTER | 621 W COLUMBIA ST EVANSVILLE, IN 47710 | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | | |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE | | | |
| IAU | | · | TAU | changes you will make to | DATE | | | |
| | elevator room | | | ensure that the deficient | | | | |
| | | storage room were | | practice does not recur? | | | | |
| | not provided w | | | Maintenance supervisor audite | | | | |
| | sprinkler cover | - | | all areas of the building to ens | | | | |
| | _ | by the Maintenance | | sprinkler heads were in place all required areas. Sprinklers a | | | | |
| | Director at the | time of each | | in place in all required areas F | | | | |
| | observation. | | | the corrective action(s) will be | oe | | | |
| | | | | monitored to ensure the | | | | |
| | 3.1-19(b) | | | deficient practice will not rec i.e., what quality assurance | eur, | | | |
| | | | | program will be put into place | e? | | | |
| | | | | Safety meeting held monthly | | | | |
| | | | | include review of fire safety | | | | |
| | | | | requirements and review of ar | - | | | |
| | | | | new construction or remodeling planned Compliance date: | g | | | |
| | | | | December 13, 2012 | | | | |
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If continuation sheet Page 11 of 11